

Chapter 19

The Army Health Service Support System

We are an AMEDD at War supporting our Army and a nation at War. The AMEDD is also in transition to a modular Army and to a new and more effective way of providing peacetime community healthcare.

We deploy the force, deploy the Medical Force and care for the Army family.

Army Medicine is an extremely complex world wide healthcare system from the active battlefield to our preeminent tertiary level research medical centers and institutions.

No soldier takes the high ground out of site of an Army medic and our AMEDD is that connection from home to the battlefield. Day in and day out we are the premier healthcare system in the world.

LTG Kevin C. Kiley, Surgeon General, U.S. Army, 2004–Present

Section I Introduction

19–1. The revolution in military medicine

Since 1775, innovations in technology, the development of new treatment modalities and the evolution of human goals have revolutionized the practice of military medicine. Military medicine has made a dedicated effort to keep pace with the constantly changing battlefield doctrine to meet the needs of both commanders and soldiers. The Army Medical Department (AMEDD) is taking major steps to incorporate advanced technology into patient care. What was science fiction yesterday is in the laboratory today, and tomorrow will be put to use by combat medics and hospital staffs. The current military health service support system is based on the Joint Health Service Support Strategy that directly supports the NMS through Global Force Health Protection Programs that focus on:

- Promoting and sustaining a healthy and fit force
- Casualty Prevention
- Casualty Care and management

19–2. Scope of the AMEDD

The AMEDD is one of the world's largest health systems, with over eight million beneficiaries. The Army health service support system encompasses all levels of medical, dental, veterinary, and other related health care from the policy and decision-making level to the combat medic in the field. The Surgeon General (TSG) directs health services within the Army. TSG commands AMEDD units and facilities within the U.S. Army Medical Command (USAMEDCOM), a MACOM, and monitors and manages health services Army-wide through the Office of TSG (OTSG), the AMEDD element of the ARSTAF. Hand in hand with other Army management systems (TAA, PPBES), the AMEDD conducts various programs specifically designed to meet the force modernization, unit readiness, research and development, preventive medicine, and patient care missions for the armed forces.

19–3. The health service support system and the Army

Medical and dental benefits are an important element of overall military compensation. Providing comprehensive, quality health care to military personnel is required by law. Other eligible Army categories, such as retirees and family members, are entitled to medical and dental care subject to availability of space, facilities, and medical and dental staff as defined by Title 10, United States Code, and other regulatory requirements. Health services are essential to recruiting and retaining a quality force. Soldiers' confidence on the battlefield is enhanced by the knowledge that they are supported by a superb medical evacuation and treatment system. A highly integrated and synchronized medical "system of systems" will be focused upon the health preservation and care for soldiers - and their families - throughout their entire period of military service. This concept of complete soldier "life cycle health management" will begin with accession and training and extend throughout the cycles of stationing and deployment / redeployment until ultimate transition from the Army rolls. The military health system embodies the concept that the Army cares for its own.

19–4. Medical support to the transforming Army

The Soldier has always been and will continue to be the pacing item for the Army. Army Medicine will maintain its focus on the sustainment of that most precious asset. The Objective Force Soldier will be protected from disease and other environmental and biological health threats and be supported by a highly capable and responsive medical system that instills confidence in soldiers, their leaders, and their families. The joint doctrine of *Global Force Health Protection* will be achieved through operational and institutional medical capabilities that are linked and delivered

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seamlessly across Service and organizational boundaries and synchronized and coordinated by joint medical command and control.

Global Force Health Protection

a. Empower Soldiers with health knowledge and programs to prevent the onset of disease. Through the advancement of vaccines, fitness and wellness studies, and a variety of predictive interventions Soldiers will avoid common health issues of today providing a healthy and fit force.

b. Enabled by advanced medical and information technologies, medical training, and organizational linkages that allow Army medicine to draw from the resources and capabilities of all military medical services as well as industry and partnerships with private and other federal health agencies. It will include the capability to rapidly project a multi-capable medical force that is tailored to the health threat, highly adaptable to emerging and changing missions, and superbly effective in providing health protection and treatment.

Section II

AMEDD mission and support to commanders

19-5. Mission of the Army medical department

The mission of the AMEDD is to “maintain the health of members of the Army, to conserve the fighting strength, to provide health care for eligible personnel, and to prepare health support to members of the Army in time of war, international conflict, or natural disaster.” This mission has two facets, both relating directly to Army combat readiness:

a. *Combat health support (CHS)*. The AMEDD is responsible for maintaining the clinical, technical, and combat readiness of medical units and personnel to support Army forces in the theater of operations.

(1) The deployable medical units of the Army carry out this task, with a heavy reliance on the Reserve Components (which constitute approximately 70 percent of the Army’s medical forces). These units are apportioned to combatant commands around the world.

(2) Tactical medical units are directly supported by the fixed installation TDA medical units assigned to the AMEDD. The TDA AMEDD mission includes the delivery of medical care to soldiers and family members at medical centers (MEDCEN), community hospitals, and clinics; dental care; veterinary services; medical research and development; education and training, combat developments, test, and evaluation; and health promotion and preventive medicine.

(3) The recruitment and retention of health care professionals and sustainment of their skills are central to the maintenance of a high quality, combat ready health service support force. Deploying the medical force is one of the AMEDD’s primary missions. Readiness to accomplish this essential function can only be ensured through the practice of medicine and its related disciplines in a patient care environment. In peacetime, the vast majority of health care professionals and technical support personnel who deploy with medical units are employed within the Army’s fixed hospitals, MEDCENs and other health care facilities. The day-to-day practice of health care professionals and their support staff in these environments is the basis for maintaining the clinical skills and teamwork necessary to care for sick and wounded soldiers during combat operations.

b. *Peacetime health care and TRICARE*. The second but equally important aspect of the AMEDD mission is to help maintain the personnel readiness of the entire Army by maintaining the health of individual soldiers and their families.

(1) Quality health care for soldiers, retirees and their families is an essential and valuable benefit. Physical readiness, good health and the knowledge that family members will be cared for contribute to the ability of each soldier to deploy and perform his or her mission in the combat environment. Projecting a healthy and protected force and caring for soldiers and their families are responsibilities of the Army Medical Command and its subordinate commands. These are accomplished through the delivery of patient care, health promotion, preventive medicine activities, education and training, and medical research and development.

(2) As military medical facilities consolidated or closed during the post-Cold War drawdown, it became increasingly necessary to use health care providers and facilities in the civilian community to augment the military health system and give soldiers, retirees, and their families the health care they expect and deserve.

(3) To meet readiness requirements and serve soldier and family health needs better, Congress directed the DOD to develop and implement a new model for military health care that would improve patients’ access to health care, assure high quality of care, and control rising health care costs. The result, TRICARE, is now the medical program for active duty service members, their family members, retirees and their family members, and survivors of all uniformed service members. TRICARE relies on interservice and civilian-military sharing of medical resources to improve accessibility of care and achieve efficiencies. A DOD program under the oversight of the Assistant Secretary of Defense (Health Affairs) (ASD(HA)), it is managed by the military in partnership with civilian contractors. Each TRICARE region has an Army, Navy, or Air Force lead agent (usually the commander of a military treatment facility) responsible for the regional program.

(4) TRICARE offers three health care options:

(a) TRICARE Prime, is a managed care option similar to a civilian health maintenance organization (HMO). Active duty service members are required to enroll in Prime. TRICARE Prime enrollees receive most of their care from

military providers or from civilian providers who belong to the TRICARE Prime network. TRICARE Prime offers less out-of-pocket costs than any other TRICARE option.

(b) TRICARE Extra, is a preferred provider option (PPO) in which beneficiaries choose a doctor, hospital, or other medical provider within the TRICARE provider network.

(c) TRICARE Standard (similar to the former CHAMPUS program), is a fee for service option in which beneficiaries can see an authorized TRICARE provider of their choice. Having this flexibility means that care generally costs more.

(d) TRICARE for life and TRICARE Plus. When beneficiaries age 65 and over become eligible for Medicare Part A, they can use TRICARE For Life (TFL) if they purchase Medicare Part B. These beneficiaries are not eligible for TRICARE Prime but are eligible to use Medicare, network and non-network providers. Some military treatment facilities will have capacity to offer a primary care affiliation program called TRICARE Plus. Enrolled beneficiaries have priority access to care at military treatment facilities; however, beneficiaries who choose to use TRICARE Extra, TRICARE Standard or TRICARE For Life may also continue to receive care in a military treatment facility on a space available basis.

(5) AA and Reserve Component soldiers on active duty for thirty days or more are enrolled in TRICARE Prime. Other beneficiaries may choose to enroll in TRICARE Prime or use either of the other TRICARE options.

(6) TRICARE was implemented in all 12 regions by FY98. Enrollment in TRICARE Prime dramatically exceeded initial projections. As TRICARE has matured, ongoing surveys have documented progressive improvement in beneficiary satisfaction with the program. Recent surveys indicate TRICARE has improved both access and satisfaction with health care.

19-6. AMEDD support to commanders

a. Commanders are responsible for the health and physical fitness of their soldiers. The AMEDD supports commanders by acting as the proponent for medical doctrine, advising commanders in all health related matters, and executing command policy in the area of health service support. The AMEDD—

- (1) Advises the command of measures to assure the health, fitness, and vigor of all members of the Army.
- (2) As directed, acts as the proponent to provide those measures needed to assure health and fitness.
- (3) Develops, trains, and maintains forces necessary for medical support to the Army in a wartime environment
- (4) Conducts routine Medical Surveillance to identify leading injury and disease problems affecting soldier's readiness and health.
- (5) Conducts field investigations of outbreaks of potential health threats from disease, environmental hazards and injuries.

b. The importance of the medical system on the battlefield is paramount. It supports the prevention of disease and non-battle injury to ensure maximum warfighting capability. When casualties occur, the medical system provides for rapid initial treatment, stabilization and evacuation to medical treatment facilities. The prompt evacuation of combat casualties is not only essential for the preservation of life, but also assists the combat commander in continuing the battle by clearing the battlefield of wounded soldiers.

Section III

The Army medical department system

19-7. Key elements

a. *The Surgeon General (TSG)/Office of The Surgeon General (OTSG).* TSG is responsible for development, policy direction, organization, and overall management of an integrated Army-wide health service system, is the medical material developer for the Army, and is the SECARMY's representative for diverse DoD joint medical training, research and health services Executive Agencies. OTSG is the ARSTAF element that develops policy and regulations on health service support, health hazards assessment, the establishment of health standards, and medical materiel. TSG also has pronency for personnel management within the AMEDD.

b. *Army Medical Department (AMEDD).* The AMEDD is comprised of personnel, units, organizations, and facilities of the Army that are under the supervision and management of TSG. In addition to USAMEDCOM, these include the special branches of the Medical Corps (MC), Dental Corps (DE), Veterinary Corps (VC), Medical Service Corps (MS), Army Nurse Corps (AN), and Army Medical Specialist Corps (SP). Also included within the AMEDD are medical enlisted soldiers in CMF 91 and DA civilians employed within AMEDD organizations and activities.

c. *Health services.* Health services are all services performed, provided, or arranged for (regardless of location) which promote, improve, conserve, or restore the physical or mental well-being of individuals or groups, and those services which contribute to the maintenance or restoration of a healthy environment. Health services include, but are not limited to, preventive, curative, and restorative health measures; medical doctrine; medical aspects of NBC defense; health promotion; assessment of medical threats and countermeasures; medical operations planning; health professional education and training; health-related research; transportation of the sick and wounded; selection of the medically fit and disposition of the medically unfit; health care administration; medical logistics; medical equipment maintenance;

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medical facility life cycle management; and the delivery of medical, nursing, dental, veterinary, laboratory, optical, and other specialized services.

d. Programming and budgeting. Since 1991, peacetime military health care has been funded through the DOD Unified Medical Program and the Defense Health Program (DHP) Appropriation, rather than the services' budgets. The ASD(HA) issues policy guidance and the TRICARE Management Activity (TMA) manages and monitors Service execution of the DHP Appropriation and the DOD Unified Medical Program. The DHP appropriation supports worldwide medical and dental services to the active forces and other eligible beneficiaries, veterinary services, medical command headquarters, graduate medical education for the training of medical personnel and occupational and industrial health care. In FY 2003, the Department implemented the DoD Medicare Eligible Retiree Health Care fund, an accrual-type fund to pay for health care provided to Medicare eligible retirees, retiree family members and survivors.

(1) The OTSG/USAMEDCOM Staff (see "One Staff," below) programs funds and manpower using both the DHP and Army appropriations. DHP funds provide for most peacetime health care operations in TDA units such as Army MEDCENs and community hospitals and for TRICARE Managed Care Support Contracts. The vast majority of AMEDD manpower is funded by the DHP. Army funding supports deployable medical TOE units and medical readiness missions.

(2) The OTSG/USAMEDCOM Staff programs for Army funds and provides its input to the Army's POM. It programs for DHP funds and provides input to the DHP POM through the TMA. Military personnel costs are programmed by TMA in the DHP POM and the programmed total obligation authority (TOA) transfers to the MPA appropriation when the budget estimate submission is prepared. Civilian personnel costs are reimbursable from DHP Operations and Maintenance Defense funds during the year of execution. Authorizations for both military and civilian personnel are on Army manpower documents.

19-8. Staff relationships and responsibilities

a. Office of the Assistant Secretary of Defense (Health Affairs). The ASD(HA) has statutory responsibility for overall supervision of health affairs within DOD and is the principal staff assistant and adviser to Secretary of Defense for all DOD health policies, programs, and activities.

b. TRICARE Management Activity. The TMA is a DOD field activity of the Under Secretary of Defense for Personnel and Readiness (USD(P&R)) that operates under the authority, control, and direction of the ASD(HA). The mission of TMA is to administer and manage TRICARE and administer, manage, and monitor Service execution of the DHP appropriation and the DOD Unified Medical Program. TRICARE lead agents coordinate health care within each TRICARE region, ensuring cooperation among military treatment facilities of all Services and efficient management of the regional managed care support (MCS) contract. MCS contractors organize networks of civilian providers to augment the military direct care system, process health care claims, and provide other services for the region.

c. Office of The Surgeon General (OTSG). OTSG has the following ARSTAF responsibilities:

(1) Assisting the SECARMY and the CSA in discharging Title 10 responsibility for health services for the Army and other agencies and organizations entitled to military health services.

(2) Representing the Army to the executive branch, Congress, DOD agencies, and other organizations on all health policies affecting the Army.

(3) Advising and assisting the SECARMY and CSA and other principal officials on all policy issues pertaining to health and military health service support to include:

(a) Policies and regulations concerning the health aspects of Army environmental programs.

(b) Health professional education and training for the Army, to include training programs for all medical, nursing, dental, and veterinary specialty areas.

(c) Research and development activities for nutrition and wholesomeness in support of the DOD Food Service Programs.

(d) Medical materiel life-cycle management.

(e) Medical materiel concepts, requirements, validity and viability.

(f) Technical review and evaluation of medical and nonmedical materiel to determine the existence of possible health hazards.

(g) Program management for Army health care automation.

(h) Army execution of the Defense Medical Systems Support Center (DMSSC).

(i) Medical aspects of the Security Assistance Program.

(j) Program sponsor for Operations and Maintenance, Army - Program 84 (Medical).

(k) Executive agent of the SECARMY for all DOD veterinary services.

(l) Medical facility life cycle management.

(m) Field medical support concepts, doctrine, training and leader development programs and user test.

(n) Medical intelligence training.

(o) Medical mobilization training.

Section IV Command and management

19–9. AMEDD reorganization

a. In 1992, the AMEDD began a reorganization effort designed to ensure the ability to accomplish the health care mission well into the 21st century. The reorganization focus was a streamlined command and control system with missions and functional areas linked to the organizational structure, with the mental complexity of the work to be performed linked to organizational level, and with command authority and accountability congruent throughout the organization.

b. The AMEDD vision of “a world class system for total quality health care in support of America’s Army at home and abroad, accessible to the total Army family, accountable to America’s people” served as the basis for the reorganization. Based on a power-down concept, the objectives for this reorganization included the creation and sustainment of a fully integrated AMEDD poised to provide cost-effective, high-quality health services. It also included a full integration of medical units in the AA and Reserve Components in both the TOE (tactical) and TDA (fixed facility) settings.

c. In 1993, the CSA approved a plan to reorganize the AMEDD. The major reorganization was completed in 1996. Health Services Command was replaced by the broader USAMEDCOM, and TSG was “dual-hatted” as its commander.

d. One Staff. In 1998, TSG directed the implementation of the One Staff concept, consolidating the staffs at OTSG and Headquarters, USAMEDCOM, Fort Sam Houston, Texas. Personnel at both locations now function as a single staff with one set of leaders who coordinate ARSTAF functions and the MACOM functions (Figure 19–1). The One Staff reduced Manning requirements by 300 positions, a 40 percent reduction from the prior organizations.

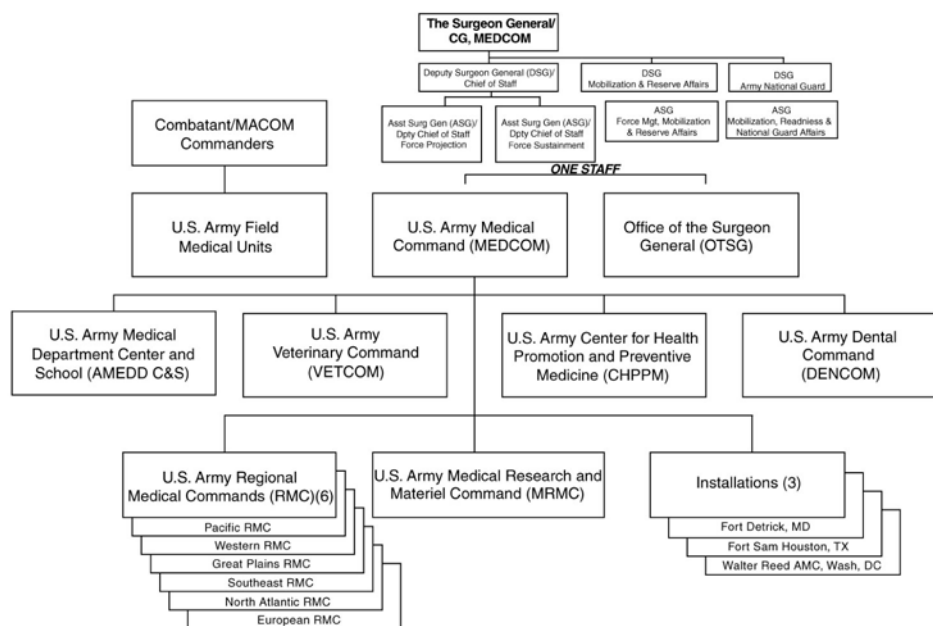


Figure 19–1. The Army medical department

19–10. U.S. Army Medical Command (USAMEDCOM)

a. The major subordinate commands of USAMEDCOM include:

- (1) U.S. Army Medical Research and Materiel Command.
- (2) U.S. Army Dental Command.
- (3) U.S. Army Veterinary Command.
- (4) U.S. Army Center for Health Promotion and Preventive Medicine.
- (5) U.S. Army Medical Department Center and School.
- (6) Six regional medical commands (RMC).

b. The consolidation of worldwide medical assets under the USAMEDCOM in 1996 greatly enhanced command and control efficiency to meet the health care needs of the Army of the 21st century. Implementation of the One Staff concept to achieve the most efficient and effective command and control structure underscored the AMEDD's commitment to continuous quality improvement and poised the AMEDD for its role in the Army Transformation.

c. The OTSG/USAMEDCOM Staff ("One Staff") is responsible for AMEDD policy, planning, and operations worldwide, with a focus on strategic planning. Its mission is to:

- (1) Provide the vision, direction, and long-range planning for the AMEDD.
- (2) Develop and integrate doctrine, training, leader development, organization, materiel, and soldier support for the Army health service system.
- (3) Allocate resources, analyze health services utilization, and conduct assessments of performance worldwide.
- (4) Coordinate and manage graduate medical education programs at the Army MEDCENs.

19–11. U. S. Army Medical Research and Materiel Command (USAMRMC)

The mission of USAMRMC is to research and develop medical solutions to protect and sustain the health and performance of the force across the continuum of operations. Mission responsibilities include:

- a.* Serving as MATDEV and logistician for medical materiel (Class VIII).
- b.* Conducting basic research, exploratory testing, engineering development and deployment development for medical materiel systems.
- c.* Serving as the programmer for Army medical facilities life-cycle management.
- d.* Performing research, development, testing, and evaluation under four critical Research Area Directorates (RADs) areas:
 - Infectious disease.
 - Combat casualty care.
 - Operational medicine.
 - Medical chemical and biological defense.
- e.* Functioning as the DOD executive agent's representative for medical research and development in the areas of biological and chemical defense, infectious diseases, combat dentistry, nutrition, HIV research, global emerging infections, accession standards and research, Gulf War research, and investigational new drugs.
- f.* Planning and executing medical logistics mobilization support and management of the Medical War Reserves Materiel Program.
- g.* Operating the NMP for medical equipment.
- h.* Providing the Army Service Item Control Center for medical, dental, and veterinary equipment and supplies.

19–12. U.S. Army Dental Command

The mission of the Dental Command (DENCOM) is to ensure dental readiness and enhance wellness by providing dental care and promoting oral health for the army by:

- a.* Serving as the proponent for meeting the dental health needs of the Army and eligible beneficiaries.
- b.* Providing command and control of the worldwide Army Dental Care System.
- c.* Allocating resources, analyzing utilization trends, and assessing performance across the DENCOM.
- d.* Training and providing qualified dental personnel for contingency operations.
- e.* Supporting mobilization of the total force by integrating Reserve Components into the Command and expanding dental capacity, as required, to receive and treat dental casualties at all levels of care.

19–13. U.S. Army veterinary service

The Army is the DOD executive agent for veterinary services, and provides veterinary support to all the military services. The Army Surgeon General is responsible for providing DOD veterinary support and directs the DOD Veterinary Service Activity, the U.S. Army Veterinary Command, and the veterinary assets in the Medical Research

and Material Command. In addition, veterinary personnel are assigned to other Army commands and DOD activities, agencies, or organization to accomplish the DOD mission. Army veterinarians and veterinary specialists support Army and DOD operations worldwide. Their missions include:

- a. Control of animal diseases communicable to man that may affect any aspect of military operations.
- b. Veterinary care for government-owned animals.
- c. Development of sanitary standards for commercial food plants providing products to DOD components.
- d. Developing lists of subsistence suppliers approved for DOD procurement.
- e. Inspection of food products at all joint procurement and storage facilities or other facilities under control of the Departments of the Army and Navy.
- f. Complete laboratory examination of subsistence products.

19–14. U.S. Army Center for Health Promotion and Preventive Medicine (USACHPPM)

a. USACHPPM was fully activated on October 1, 1995. This organization is an outgrowth of the former U.S. Army Environmental Hygiene Agency. The mission of USACHPPM is to provide health promotion and preventive medicine leadership and services to identify, assess and counter environmental, occupational, and disease threats to health, fitness, and readiness in support of the NMS. Mission responsibilities include but are not limited to:

- (1) Disease & Injury prevention control.
- (2) Health Promotion & Wellness.
- (3) Environmental/Medical Surveillance.
- (4) Occupational, Environmental & Health Surveillance.
- (5) Health Risk Communication.
- (6) Health Threat Assessment & Countermeasures.
- (7) Health Risk Assessments.
- (8) Medical, Occupational, and Environmental Epidemiology.
- (9) Population and Environmental Health Risk Assessments.
- (10) Health Policy Development and Review
- (11) Graduate Medical Education
- (12) Continuing Medical Education
- (13) Disease outbreak investigation

b. The Commander, USACHPPM is designated as the Functional Proponent for Preventive Medicine (FPPM). The Proponency Office for Preventive Medicine (POPM) is the staff element that supports the FPPM in all issues of preventive medicine policy and strategy development.

19–15. U.S. Army Medical Department Center and School

The mission of the AMEDD Center and School is to:

- a. Develop, integrate, coordinate, implement, evaluate and sustain training and training products for active and reserve medical forces worldwide in accordance with AR 350–1.
- b. Develop, integrate, analyze, test, validate, and evaluate concepts, emerging doctrine and medical systems, and doctrine and training literature.
- c. Conduct all AMEDD officer, enlisted, and civilian proponency functions, personnel inventories, and life-cycle management of all career fields.
- d. Develop concepts, systems, and force structure for combat health service support.
- e. As the integration center for all doctrine and training requirements; systematically develop courses, training devices, manuals and sustainment materials for readiness.
- f. Provide training, education, and evaluation of AMEDD personnel.
- g. Test and evaluate new and replacement items of medical equipment.
- h. Serve as proponent for Force Health Protection in theaters of operation.
- i. Conduct healthcare studies to improve the operational efficiency and effectiveness of the AMEDD.
- j. Provide statistical and analytical consultation to the AMEDD, with secondary support to subordinate organizations within the MEDCOM; provide decision support expertise to AMEDD senior leadership; promote data quality, integrity, and standardization across the AMEDD; provide biometric database management and programming expertise to the AMEDD; provide the AMEDD with medical record coding guidance and training for medical records personnel.
- k. Function as the DoD executive agent's representative for joint training and pharmaceutical standardization in the areas of defense medical readiness training, joint medical executive skills, and the pharmacoeconomic center.

19–16. USAMEDCOM Acquisition Activity

The mission of the USAMEDCOM Acquisition Activity is to plan, develop, and implement an integrated delivery system of contracting support to meet the needs of all USAMEDCOM activities.

19–17. Regional Medical Commands (RMCs)

a. RMCs are the key operational element for the delivery of health care services for geographical regions within the MEDCOM. RMCs are major subordinate commands (MSCs) operating under the supervision of the commander. Figure 19–2 reflects regional boundaries for medical and dental commanders. Mission responsibilities include:

(1) Regional command and control of an affordable, multidisciplinary, customer-focused, quality military health service system.

(2) Supporting the readiness requirement of the Army.

(3) Developing and sustaining technical health care and leader skills in support of USAMEDCOM readiness goals.

(4) Allocating resources, analyzing utilization, and assessing performance across the RMC Figure 19–2. RMCs and Collocated Dental Commands

b. As the primary integrator of medical readiness, the RMC is responsible for:

(1) Daily utilization of TOE–TDA medical assets, integrating Active and Reserve training, and development of mobilization requirements.

(2) Budgeting, defending, and allocating readiness costs and funding.

(3) Preplanning the medical treatment facility (MTF) professional backfill requirements during deployment by expanding network coverage, shifting RMC assets, and coordinating Reserve Component coverage.

(4) Ensuring that Army medical readiness requirements are fully integrated into the activities of DOD health care regions.

(5) Conducting training exercises in MTF mobilization, professional backfill activities, and deployment actions.

(6) Providing medical planning and preparation programs for worldwide contingency operations.

(7) Sponsoring readiness-based clinical research.

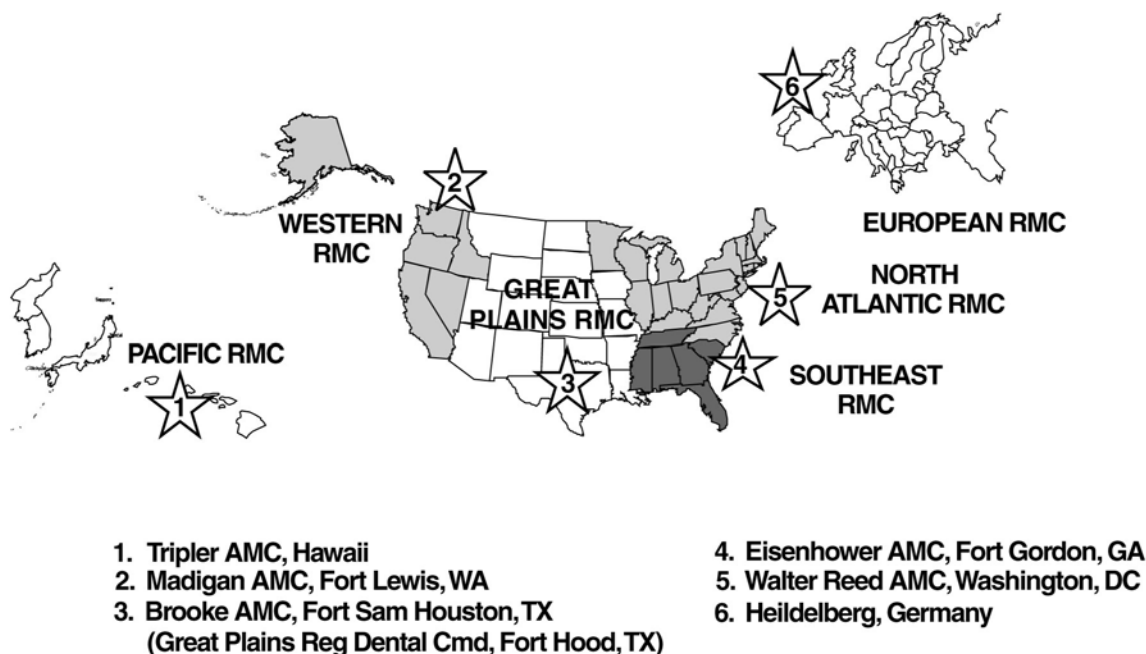


Figure 19–2. Regional boundaries for medical and dental commanders

19–18. AMEDD role in combat service support units

a. In addition to its fixed health care facilities, the Army maintains medical units with a combat service support (CSS) mission within all deployable commands. These medical units work in concert with logistics and personnel units to form the CSS core for Army forces. The deployable medical assets consist of TOE units in both the AA and Reserve Components. The AA medical units are integral to U.S. Army Forces Command, U.S. Army Europe, USARSO, and USARPAC. Deployable medical units range in size, scope of mission, and capacity from medical detachments to theater hospitals. Collectively they establish an integrated continuum of medical evacuation and treatment from point of injury on the battlefield, to the corps/COMMZ, and eventually to specialized treatment in CONUS.

b. In the event of mobilization, AMEDD Reserve Component medical units will often be among the earliest deploying forces. With approximately 70 percent of the medical force in the Reserve Components, the AMEDD truly exemplifies The Army. Well-trained and combat ready Reserve Component medical units are absolutely essential for ensuring that the CHS missions of the Army are accomplished during periods of mobilization. Under the Professional Officer Filler Information System (PROFIS) qualified Active Army personnel serving in TDA units are designated to fill FORSCOM early deploying MTOE units, USARPAC, USAREUR, and EUSA forward deployed units upon execution of an approved JCS OPLAN or upon execution of a no-plan contingency operation. Individuals pre-designated from fixed Army health care facilities will provide a large portion of the professional personnel to units deploying to and already stationed in the theater of operations.

c. A key enabler that will be integrated in CSS units as well as the Joint force is Medical Communications for Combat Casualty Care (MC4). MC4 is being fielded to integrate: the Joint Medical Information Program (TMIP); the Battlefield Medical Information-Theater (BMIS-T); the Composite Health Care System II-Theater (CHCSII-T); the US Transportation Command (TRANSCOM) Regulating and Command and Control Evacuation System (TRAC2ES); the Defense Medical Logistics Standard Support (DMLSS); and the Defense Medical Surveillance System (DMSS). MC4 fully integrates the global medical network with a fully integrated operational architecture and a Global Information Grid (GIG) infrastructure. MC4 will enable commanders to effectively synchronize medical care on any battlefield, worldwide.

19-19. Staff surgeons

a. The senior AMEDD officer present for duty with a headquarters (other than medical) will be officially titled—

- (1) The “Command Surgeon” of the ACCs and the overseas MACOMs.
- (2) The “Surgeon” of the field command (e.g. corps, CONUSA).
- (3) The “Director of Health Services (DHS)” at the installation level.

b. The surgeon and DHS are responsible for the staff supervision of all health matters and policies, except dental and veterinary matters. The DHS and the director of dental services (DDS) will serve on the installation commander’s staff. Normally, the commander of the MEDCEN or medical department activity (MEDDAC) is the DHS, and the commander of the Army dental activity (DENTAC) is the DDS.

19-20. Health service logistics

a. Health service logistics is integral to Army health service support and is managed by the AMEDD. This gives the command surgeon the ability to influence and control the resources needed to save lives. TSG establishes medical logistics policies and procedures within the framework of the overall Army logistics system. Health service logistics includes the management, storage, and distribution of medical materiel, blood and blood products, optical fabrication, and medical equipment maintenance. The medical commodity (Class VIII) has characteristics that make it distinctly different from other classes of supply. Medical materiel includes pharmaceuticals, narcotics, and blood products that are potency and shelf life (dated), and require special handling and security. Most items are subject to the regulations and standards of external agencies such as the Food and Drug Administration, the EPA, the Drug Enforcement Agency and the Joint Commission on Accreditation of Healthcare Organizations. Medical logisticians have extensive knowledge of those requirements as they relate to health service support.

b. The Single Integrated Medical Logistics Manager (SIMLM) mission designates a single organization or Service component to manage and provide health service logistics support to joint forces operating in the theater. Blood is the only medical material not directly under control of the SIMLM. Blood supplies are coordinated and managed by the Joint Blood Program Officer in each of the Combatant Unified Commands.

19-21. Medical Reengineering Initiative (MRI)

a. In October 1993, the AMEDD initiated the redesign of CHS. The initiative focused on split-based operations; improving tactical mobility; reducing footprint; fixing communications; exploiting IT; and flexibility, deployability, and tailorability. The resulting new design supports the tenets of Army Force XXI and The Army Transformation. It enhances the combat commander’s operational tempo; reduces the logistics burden; and, most importantly, reduces the morbidity and the mortality of wounded soldiers. MRI will convert the entire echelons above division/echelons above corps (EAD/EAC) CHS force of the AMEDD. MRI represents a reorganization of CHS units, not merely equipment modernization (although equipment modernization will occur simultaneously).

b. MRI encompasses 391 medical units among all three Army components. This major Army initiative will convert/activate 165 of the 391 medical units by the end of FY 05. MRI will provide full spectrum CHS to the Army in joint operations. The MRI will ensure that medical units can rapidly deploy with sufficient capability to meet the most demanding missions. The MRI design facilitates scalability through easily tailored capabilities-based packages and includes hooks for augmentation, to permit rapid integration of additional enabling capabilities.

19-22. Secretary of the Army’s executive agent representative for DoD executive agencies (DoD EA)

a. Executive Agent representative: An Executive Agent is the Head of a DoD Component (SECARMY) to whom the Secretary of Defense or the DepSecDef has assigned specific responsibilities, functions, and authorities to provide

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defined levels of support for operational missions, or administrative or other designated activities that involve two or more of the DoD Components. The DoD Executive Agent may delegate, to a subordinate designee within that official's Component (TSG), the authority to act on that official's behalf for any or all of those Executive Agent responsibilities, functions, and authorities assigned by the Secretary of Defense or the DepSecDef.

b. In addition to the DoD EAs embedded in AMEDD Major Subordinate Commands, TSG serves as the Executive Agent's representative for other essential joint medical agencies, to include:

- (1) Armed Forces Institute of Pathology
- (2) Joint Military Vaccine Agency
- (3) Armed Forces Epidemiological Board
- (4) Armed Forces Medical Library
- (5) Armed Forces Pest Management Board
- (6) Armed Services Blood Program Office
- (7) Civilian Employee Occupational health and Medical Service Clinic
- (8) DiLorenzo TRICARE Health Clinic
- (9) DoD/VA Clinical Guidelines Development
- (10) DoD Veterinary Services Activity
- (11) Joint Readiness Clinical Advisory Board
- (12) Joint Medical Surveillance for Deployments
- (13) Nutritional Education and Standards
- (14) Regional Tri-Service Medical Logistics Support Program

Section V

Summary and references

19–23. Summary

This chapter has discussed the mission, organization, functions, and staff relationships of the AMEDD. The health service support system encompasses all levels of medical, dental, veterinary, and other related health care, from the policy and decision-making level to the combat medic in the field. Health services within the Army are directed and monitored by TSG through USAMEDCOM and the Office of TSG. TRICARE has markedly altered the peacetime military health system. MRI will transform the AMEDD's TOE medical units to support The Army of the future.

19–24. References

- a. DOD Directive 5136.1, *Assistant Secretary of Defense for Health Affairs*.
- b. Army Regulation 10–5, *Headquarters, Department of the Army*.
- c. Army Regulation 10–87, *Major Army Commands in the Continental United States*.
- d. DoD Directive 5100.88, *DoD Executive Agencies*.
- e. Army Regulation 40–1, *Composition, Mission, and Functions of the Army Medical Department*.
- f. Army Regulation 40–4, *Army Medical Department Facilities/Activities*.
- g. Army Regulation 40–61, *Medical Logistics Policies and Procedures*.
- h. Field Manual 4–02, *Force Health Protection In A Global Environment*.
- i. US Army Medical Command Regulation 10–1, *Organization and Functions Policy*.
- j. U.S. Army Medical Command Memorandum 10–2, *Organizations and Functions*, Headquarters, U.S. Army Medical Command/OTSG Regulation 10–32.
- k. U.S. Army Medical Department Website, www.armymedicine.army.mil.